CHAPTER 5

Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market

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Key Points

- Premium assistance—the use of Medicaid funds to purchase private market plans—is one approach that states may use to expand the program to previously ineligible, low-income adults. Arkansas and Iowa are using premium assistance to purchase plans on the exchange through Section 1115 research and demonstration waivers, and other states have expressed interest in this approach.
- States cite various rationales for considering premium assistance, including easing the transition from Medicaid to exchange plan eligibility and improving access to care by enrolling individuals in private market plans. Additionally, relying on the private market could enable states with limited managed care or provider capacity to serve the influx of new enrollees. States also point to the potential for Medicaid enrollees to substantially increase enrollment in the exchanges, which in turn could improve the risk pool and encourage issuer participation.
- Under premium assistance, state Medicaid programs do not retain authority over many aspects of care, which they would oversee under most Medicaid managed care contracts. Instead, they are essentially buying coverage in a separate system that was not specifically designed for a Medicaid population.
- While the approved premium assistance waivers retain certain protections for exchange plan enrollees—including retroactive coverage, benefit appeals rights, and exemptions for medically frail enrollees—they have notable differences from traditional Medicaid. For example:
  - Enrollees will no longer be entitled to non-emergency medical transportation in Iowa, although Medicaid will continue to provide certain benefits not covered by exchange plans, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for young adults in both states.
  - Iowa and Arkansas also are instituting new approaches to cost sharing that could affect enrollment and utilization, although Medicaid's limit to 5 percent of income remains in force.
- Federal policy requires Section 1115 waivers to be budget neutral, which means that federal Medicaid spending must be equal to or less than it would be without the demonstration. Whether states actually achieve budget neutrality will depend on the costs of coverage, the health of the population that enrolls, and the interactions with other federal programs.

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Premium assistance, or the state purchase of private market plans on behalf of Medicaid enrollees, is attracting interest as an alternative to expanding traditional Medicaid coverage to previously ineligible low-income adults.[1] After the U.S. Supreme Court ruling in June 2012 effectively made Medicaid expansion an option for states, two of the 28 states moving forward have taken this approach. Through Section 1115 research and demonstration waivers, Arkansas and Iowa are using Medicaid funds to purchase exchange plans for residents who are newly eligible for Medicaid.[2] While the premium assistance approach is not new to Medicaid, it previously has served a relatively small number of enrollees, with most programs covering fewer than 2,000 people and primarily those with employer-sponsored coverage (GAO 2010). The extension of premium assistance to the purchase of exchange plans raises a number of considerations for the program.

Medicaid has long served as a payer of last resort for low-income people who have limited insurance options, including families with children, pregnant women, individuals age 65 and older, and people with disabilities. However, with the extension of Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) to low-income adults, the majority of whom historically were excluded from the program, the role of Medicaid as a coverage source and a payer in the health care system has expanded. Estimates suggest that almost half of those gaining health insurance coverage in 2015 (relative to the pre-ACA baseline) are expected to enroll in Medicaid and the State Children's Health Insurance Program (CHIP) (CBO 2014). With the movement of Medicaid enrollees into the exchange market through premium assistance, Medicaid will serve as a larger purchaser of coverage with the potential to alter exchange markets by broadening the risk pool and affecting premiums and competition.

The broader use of premium assistance also moves the program further away from a source or a negotiator of Medicaid-specific coverage toward more of a purchaser of private market coverage. While most Medicaid enrollees currently receive their benefits through private managed care plans, the contracts give states control over how services are provided and access is assured. Additionally, states have oversight authority and can require certain data reporting to ensure program integrity. In contrast, in the premium assistance approach, Medicaid agencies no longer have direct authority over the plans and are instead buying coverage in a separate system designed for a non-Medicaid population. This extension into the exchange market and the shift in the state agencies' role leads to a number of questions regarding the use of exchange plans to provide coverage for Medicaid enrollees.

While the approved waivers mostly maintain states' requirements to provide Medicaid benefits and cost-sharing protections to exchange plan enrollees, there are several notable differences from traditional Medicaid. These variations are not unique to the premium assistance approach as other states, such as Michigan and Pennsylvania, have secured waivers to test alternatives to a straight Medicaid expansion by altering their cost-sharing or benefit design. But as they are not purchasing exchange plans for Medicaid enrollees, they are not the focus of this chapter.

In the Arkansas and Iowa premium assistance waivers, there are some instances where Medicaid continues to provide benefits not covered by exchange plans, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19- and 20-year-olds. In other instances, benefits,

such as non-emergency medical transportation (NEMT), were waived and the enrollees will no longer be entitled to them. In terms of cost sharing, Medicaid's limit to 5 percent of income remains, but both states are instituting new approaches to cost sharing that could affect enrollment and utilization. Consumer protections, such as retroactive coverage, benefit appeals rights, and exemptions for the medically frail, remain in place in these waivers.

Moreover, while press accounts and discussions of premium assistance often focus primarily on its appeal to voters and legislators in some states, there are a number of other rationales that are driving interest in the approach. States cite the potential to smooth the transitions for individuals moving from Medicaid to exchange plan eligibility. States also have suggested that enrolling Medicaid-eligible individuals in private market plans with commercial provider networks will improve their ability to access care. States that have limited managed care or provider capacity may turn to the private market to serve the expanded Medicaid population. Finally, as mentioned, there is the potential for Medicaid enrollees to substantially increase enrollment in the exchanges, perhaps altering the risk pool and attracting additional issuers (Allison 2014, CMS 2014a, and CMS 2014b).

The expanded use and mandatory nature of the recent premium assistance models raise a number of important policy considerations and areas for monitoring.[3] While it will be several years before the data are available that can provide a full assessment, raising questions now can help guide future analysis and evaluation. This chapter provides a brief overview of the history of the use of private plans in Medicaid and then lays out questions surrounding the use of premium assistance for the new adult group as well as the possibility of extending it further. Specifically, the chapter examines:

- differences between the use of managed care in Medicaid and the use of premium assistance to purchase exchange plans;
- reasons states might choose premium assistance to expand Medicaid;
- differences between Medicaid and premium assistance on benefits and cost sharing;
- protections that remain available to Medicaid enrollees;
- potential cost implications and effect on the broader exchange market; and
- the need for a thorough evaluation of this approach to expansion.

How Medicaid Managed Care and Premium Assistance Differ on State Oversight and Payment Policy

Medicaid has a long history of offering private insurance through managed care and premium assistance.[4] However, while both approaches involve the purchase of coverage offered by private plans, there may be fundamental differences in terms of the state's oversight and management functions as well as the method for determining payments. The majority of Medicaid enrollees receive their benefits through private managed care plans, which contract directly with state Medicaid programs and must comply with state and federal Medicaid purchasing requirements. In contrast, in the premium assistance approach, states buy coverage through a separate system (such as the exchanges or employer-sponsored coverage) that was designed to serve a non-Medicaid population. Below we discuss the extent of the use of managed care compared to premium assistance, the varying degrees of oversight in each, and their differing methods for determining plan payments.

While a few states have been using managed care in Medicaid since the early years, many states instituted large expansions of Medicaid managed care beginning in the mid-1990s. As of fiscal year

2011, approximately half of Medicaid enrollees were in comprehensive risk-based managed care and 72 percent were served through some form of managed care arrangement (MACPAC 2014).[5] Additionally, the vast majority of individuals made newly eligible for Medicaid in 2014 also are expected to obtain benefits under a managed care arrangement (Sommers et al. 2013). States have pursued the use of managed care for a number of reasons, including their belief that it provides better care coordination and improved program accountability for access and quality. By paying managed care organizations (MCOs) a set rate per member per month (or capitated payment), states can also capitalize on more predictable budgetary expenditures, while still maintaining program management and oversight (MACPAC 2011).

State contracts with MCOs establish the terms under which the plans will deliver services to enrollees and serve as a mechanism to enforce both state and federal standards. Although the terms of each contract are governed in part by federal rules, states have considerable flexibility in determining particular parameters within established guidelines. As such, there is variation among the states as to the specificity and complexity of contract requirements. For example, the plans are responsible for establishing and maintaining provider networks, but the states can stipulate certain network standards and must ensure that the networks meet minimum federal requirements in order to assure appropriate access. States also establish contract provisions relating to improved care and accountability. For example, states can require plans to assign each member to a primary care physician and to provide care coordination and management. Additionally, states can establish quality and performance standards and data collection and reporting requirements in order to monitor whether the plans are meeting the contract requirements. Finally, state contracts with MCOs describe the sanctions or other enforcement mechanisms states can apply if the contract terms are not met.

The direct purchase of private market plans through premium assistance has been relatively limited, despite having been permissible within federal requirements since the enactment of Medicaid. While many states have chosen to implement premium assistance programs, most have enrolled fewer than 2,000 people and generally have been limited to employer-based plans, as very few states have chosen to provide assistance for the purchase of individual policies. The low enrollment likely is due to three key factors. The first relates to eligibility—a limited number of Medicaid-eligible persons have access to comprehensive employer-sponsored coverage, and, prior to the ACA, it was difficult for many people to qualify for individual market coverage (GAO 2010 and GAO 2009). Specifically, many individual market plans were not required to cover comprehensive benefits and were allowed to exclude persons for a variety of reasons, including pre-existing conditions (Doty et al. 2009). Second, premium assistance requires states to make a determination of cost-effectiveness, meaning that covering an individual in an employer-based or other private market plan would need to cost the same or less than providing comparable coverage in Medicaid. In making this assessment, states also need to factor in the administrative costs of the program as well as any costs to wrap around benefits or cost sharing. Cost-effectiveness often was hard to achieve as the use of deductibles and higher cost sharing has increased in employer-sponsored plans (KFF and HRET 2014). In the individual market, plans typically had high premiums and deductibles because they had been rated based on a person's demographic, health, and other characteristics (Doty et al. 2009). Finally, the programs were complicated to administer, as states are required to provide wrap-around coverage for benefits that are not covered in the private market plan, cover the cost of any additional premiums and cost sharing, and complete an assessment of cost-effectiveness.

The ACA changed the insurance coverage landscape, making the use of premium assistance through the purchase of individual market plans

a more viable option. By mandating a core set of comprehensive benefits and setting a cap on out-of-pocket costs, as well as restricting the use of individual rating and discrimination based on preexisting conditions, many of the earlier obstacles to the purchase of individual market plans faded. The U.S. Department of Health and Human Services (HHS) issued regulations in July 2013 allowing for the enrollment of individuals eligible for Medicaid in plans in the individual market, including enrollment in exchange plans, under certain conditions (42 CFR 435.1015). While states can use existing statutory authority to enroll individuals into exchange plans, no state has done so in part because Section 1115 demonstration waivers allow them to test additional features, including mandatory enrollment of adults in the expansion group, imposition of higher cost sharing for some enrollees, restrictions on mandatory benefits, and changes to provider payment rules. Other states have expressed interest in using Section 1115 waiver authority for premium assistance demonstrations, although, as of January 2015, only Arkansas and Iowa have received approval for their waivers.[6]

Typically, state Medicaid agencies have direct oversight of the Medicaid delivery system through agreements with fee-for-service providers or contracts with MCOs (42 CFR 438.6).[7] However, in both traditional employer-focused premium assistance programs and exchange plan-based premium assistance demonstrations, Medicaid is purchasing another source of coverage and does not directly contract with the insurers; therefore, Medicaid regulations do not apply. Employers (in the case of employer-sponsored insurance), state departments of insurance, and state or federal exchanges (in the case of exchange plans) all have roles in establishing insurance standards such as provider network composition, claims payment timeliness and accuracy, utilization management, financial solvency, and customer service. While these standards may or may not align with state and federal Medicaid rules, a state Medicaid agency could, in its role as purchaser, establish an independent relationship with the plans to institute such standards.

In addition, state Medicaid agencies that provide direct Medicaid or contract with MCOs have access to a variety of data for monitoring and oversight, including claims or encounter data, provider enrollment data, and payment and coverage policies, although there are limitations and timeliness concerns with these data. Medicaid MCOs are required to collect and report on enrollee and provider characteristics, including encounter data that detail enrollee service use (42 CFR 438.242). Medicaid programs that purchase exchange plans may not have access to the same level of information on service use, provider payment, or coverage and utilization management policies. The waivers require the memoranda of understanding (MOU) between the state Medicaid agencies and the exchange plans to include reporting and data requirements that are necessary to monitor and evaluate the premium assistance approach. Since no such MOUs have yet been made public, however, it is not clear what level of data access and oversight authority the Medicaid agencies will have. Additionally beyond these MOUs, the state department of insurance could require exchange plans to share data and performance information with Medicaid.[8]

Medicaid managed care and premium assistance coverage also differ in how they set payments to plans. Medicaid programs use a variety of methods to set capitation rates for their managed care plans, but all are required to pay rates within an actuarially sound range (42 CFR 438.6(c)). Among 20 states with comprehensive managed care highlighted in a recent report, 13 used an administrative process in which a specific rate is set by the state and offered to plans, 4 used a competitive bidding process, and 3 used a negotiation process (Courtot et al. 2012). Regardless of the approach, the capitation rate for a Medicaid managed care plan is based on the estimated cost of serving a specific population of Medicaid enrollees. In contrast, premiums for exchange plans and other private market plans are determined using the rating rules that apply to that market, and their prices reflect the cost of the entire population—both Medicaid and non-Medicaid—in that market.

Reasons States Might Choose Premium Assistance

Most accounts of the adoption of premium assistance have highlighted some states' desire to rely on a private insurance model to provide coverage for the Medicaid expansion population. This private market focus also aligns with the view held by some that Medicaid was designed for the most vulnerable and that the private market may better serve the majority of adults. However, there are a number of other compelling rationales for choosing an alternative approach to the expansion that relies on exchange plans beyond the appeal of purchasing a private market plan. They include: reducing churning between plans, improving access to providers, supplying a delivery system in states that do not otherwise have the capacity in their Medicaid program, and strengthening the exchanges by increasing the number of enrollees and participating issuers.

Due to changes in income and family circumstances, an estimated 6.9 million people are expected to move from Medicaid coverage to exchange coverage or vice versa each year (Buettgens et al. 2012). Referred to as churning, this movement between programs increases administrative costs and disrupts continuity of care (MACPAC 2013). Premium assistance may lessen the impact of churn because, if Medicaid-eligible individuals are enrolled directly into exchange plans, they can stay in the same plan even if their income increases and they lose Medicaid coverage. In Arkansas, enrollees have a choice of at least two exchange plans and the networks are required to be the same as those offered to non-Medicaid enrollees (CMS 2014a). In Iowa, enrollment currently is limited to one exchange plan or the state's Wellness plan, following the withdrawal of one of its carriers from the market (Iowa 2014a and CMS 2014b).[9] If enrollees choose to remain with the same exchange plan as their Medicaid eligibility changes, and the transfer between Medicaid and exchange enrollment is seamless, gaps in coverage resulting from system or other coordination issues that might occur in other states could be minimized. At this point, no data are available that would allow for the examination of changes in eligibility between programs and continuity of coverage, although historically, transitions between Medicaid and CHIP have resulted in gaps in coverage (Harrington et al. 2014).

There are other approaches to minimizing the impact of churn besides premium assistance. For example, states could require or encourage health plans to offer products across payers.[10] By encouraging issuers to offer plans in both the Medicaid and exchange markets, disruption in coverage and discontinuity of care for enrollees moving between Medicaid plans and exchange plans could be minimized. The extent to which this will actually work depends upon whether or not the plans offered to the Medicaid population are the same as those offered to consumers using premium tax credits to purchase exchange plans. For example, if the networks are not the same in both plans, an enrollee might be forced to change providers when moving from Medicaid to exchange coverage, even if the individual stays with the same carrier. This same issue could arise in the premium assistance approach if the plans available to the Medicaid-eligible population are not the same as those available to the exchange-eligible population. An alternative option for mitigating the impact of coverage changes is to establish transition plans for individuals moving between coverage sources.[11]

Another argument often made in support of premium assistance is that it will improve Medicaid enrollees' access to providers. Medicaid must provide enrollees with access to care comparable to that of the general population (§1902(a)(30)(A)). Through the use of premium assistance, the assumption is that the purchase of a commercial product, by definition, is providing this equal access. Additionally, states have suggested that, by paying higher commercial or commercial-like rates to providers through the exchange plans,

access will improve as a result (Allison 2014). Just one-third of physicians accept new Medicaid patients, with payment rates that are typically below commercial levels cited as a reason for low participation (Decker 2012). While payment rates are proprietary, there have been indications that exchange plans may pay higher rates than Medicaid, but lower than other private payers, such as employer-based coverage (Pittman 2013). When enrolling in an exchange plan, a Medicaid beneficiary could have more options for providers if there is a wide range of plans with robust networks to choose from. As mentioned, in the two existing waivers, enrollees are required to have the choice of at least two exchange plans, although, as noted above, currently only one exchange plan is available in Iowa (CMS 2014a and CMS 2014b).

There are yet little data to evaluate the extent to which premium assistance affects access, and despite regulatory protections, there have been reports of access and network limitations in both Medicaid and exchange plans.[12] For many services, Medicaid enrollees have access comparable to similarly situated adults with employer-based coverage, although there are areas for improvement (MACPAC 2012). (Comparisons to the individual market, which is most similar to exchange plan coverage, are not available.) Moreover, insurers often design exchange plans with narrower networks relative to other private plans as a cost-containment strategy, having few other options to limit costs with the ACA's prohibition on preexisting condition exclusions and rate setting based on health status (Corlette et al. 2014 and McKinsey 2013). As a result, in-network provider participation may be limited, and the cost sharing for out-of-network care far higher.[13] While there is anecdotal information, in the form of complaints, about the narrow networks and lack of transparency around which providers are in- or out-of-network, there is limited evidence yet as to the overall impact of these things on access and utilization.[14, 15] Beyond provider participation and network assessments, another measure of the adequacy of Medicaid and exchange plan coverage may be whether or not enrollees are able to access the care they need in a timely fashion. Data made available through ongoing surveys of enrollees and comparisons across eligibility categories will be important to monitor whether access is a problem in Medicaid and exchange plans.

In addition to the potential to reduce churn and improve access, the use of premium assistance may be appealing for states because of constraints on existing Medicaid provider capacity and the composition of their exchange market. Specifically, in states where providers are unable to absorb the new patient population or in cases where there is limited or no managed care infrastructure, it may be difficult for a state to expand Medicaid using its existing provider network. Using exchange plans that may pull from a different provider pool could result in broader access for enrollees who otherwise may have difficulty finding a provider. Additionally, premium assistance may be attractive to states as a means of expanding the risk pool purchasing coverage in the exchanges. For example, in states where the uninsured population is lower income, adding the Medicaid-eligible population to the exchange market may help bolster enrollment. Depending on the composition of the population, this may improve the risk pool (for example, if the Medicaid population is younger than other exchange enrollees) and may encourage additional insurers to join the exchange.

How Medicaid and Premium Assistance Differ on Benefits and Cost Sharing

Certain federal Medicaid benefit requirements and premium and cost-sharing protections are not mandated in exchange plans. In approving premium assistance waivers, however, the Centers for Medicare & Medicaid Services (CMS) has said states must arrange with exchange plans to provide any necessary wrap-around benefits and

cost sharing, or seek to waive them (CMS 2013b). Because of these conditions, premium assistance involves more than the purchase of a commercial insurance plan and differs from traditional Medicaid in several ways described in greater detail below. It also is important to note that benefit and cost-sharing waivers are not unique to the use of premium assistance.

Comparison of benefits in Medicaid and exchange plans. Medicaid enrollees who come in through the new adult eligibility pathway are statutorily required to receive the alternative benefit package (ABP). The ABP must cover certain services, such as family planning services and supplies, and EPSDT services for children under age 21. It also must comply with mental health parity rules and provide the 10 essential health benefits (EHB) also required in exchange plans (42 CFR 440.345 and 42 CFR 440.347). In contrast, exchange plans are required to offer only the 10 EHBs, although the package includes benefits that are optional under traditional Medicaid, such as rehabilitative services (45 CFR 156.110). By choosing to define the ABP as the package covered by the exchange plans, states adopting the premium assistance approach to Medicaid expansion will either need to cover any missing benefits or secure a waiver of benefit requirements from CMS, in addition to the waiver of other provisions that may be required to provide exchange plan premium assistance.[16]

Medicaid includes benefits important to high-need, low-income populations that are unavailable in exchange plans. For example, EPSDT includes periodic screening services, such as a comprehensive physical exam including a health and developmental history as well as vision, dental, and hearing services. Under EPSDT, states also are required to provide any additional services that are medically necessary to diagnose, treat, correct, or reduce any conditions discovered, regardless of whether or not these services are covered in the state's plan (42 CFR 441.50-441.62). Both Arkansas and Iowa are required to wrap EPSDT benefits, meaning that each state will provide unavailable services through their fee-for-service systems to those 19- and 20-year-olds enrolled in exchange plans. Enrollees will receive both an exchange plan insurance card and a Medicaid client identification number (CIN); information on how to use this number for wrapped benefits, as well as which services are covered directly through Medicaid, will be provided through the eligibility notice (CMS 2014a and CMS 2014b).[17]

States also must ensure that Medicaid enrollees have the necessary transportation to medical examinations and treatment (42 CFR 440.170(a)). This benefit is most often used to get to behavioral health (including mental health services and substance abuse treatment) and dialysis appointments (MJS & Company 2014). NEMT is not typically provided by commercial insurers and is important for Medicaid enrollees who may not be able to attend an appointment or face an increased financial burden if transportation is not provided (MACPAC 2012). Additionally, the lack of transportation may impact provider willingness to participate if large numbers of enrollees do not show up for scheduled appointments. Iowa secured a temporary, one-year waiver of NEMT and was required to evaluate the impact of the waiver on access to care (CMS 2014b). In its September 2014 request to continue the exclusion in year two, the state reported that enrollees are using services and therefore access has not been affected without NEMT. Even so, almost half (between 42 and 49 percent) of enrollees needed assistance, either from a friend or family member or through public transportation, to get to a health care visit in the last six months, and between 8 and 18 percent always needed assistance (Iowa 2014c). Despite the concerns these data raise regarding beneficiary access, CMS granted an extension of the NEMT waiver until July 31, 2015 to allow for additional data collection (CMS 2014b). Arkansas received approval for an amendment to require prior authorization for NEMT, but will continue to provide the benefit, when authorized, through its fee-for-service system (CMS 2014a).

States adopting premium assistance also must make other operational decisions regarding benefits, including the approach to wrapping benefits and how to educate consumers and providers about accessing services. While Arkansas and Iowa are providing wrap-around coverage through their fee-for-service systems, states also could carve out certain benefits, such as NEMT, and offer them through a managed care organization. Arkansas and Iowa are required to send enrollees details on the services covered outside the exchange plans as well as post the information on their states' Medicaid websites and provide the information through call centers and exchange plan issuers. Medicaid's prior experience with premium assistance yielded little information regarding individuals' access to wrapped benefits or the administrative process that ensuring access entails. As such, examination of these will be important in monitoring and evaluating these demonstrations.

Cost-sharing requirements in premium assistance waivers. States adopting the premium assistance approach to expansion also are pursuing waivers of Medicaid premium and cost-sharing protections so that all enrollees pay something, even nominally, toward the cost of coverage.[18] The notion of personal responsibility in the form of financial contribution resonates deeply with some policymakers, and the pursuit of financial responsibility among enrollees is not limited to the premium assistance approach to expansion.

States already can require certain groups of Medicaid enrollees to pay cost sharing, but are precluded from charging premiums for enrollees with income at or below 150 percent of the federal poverty level (FPL) (42 CFR 447.55). Per-service charges are limited to nominal amounts for individuals with income at or below 100 percent FPL and are prohibited for certain services (42 CFR 447.56(a)(2)). Additionally, all cost sharing (including premiums and per-service charges) incurred by members of a family is subject to an aggregate limit of 5 percent of the family's income, and the state must have a process in place to track spending toward the limit that does not rely on documentation from the enrollee (42 CFR 447.56(f)).

While not fully aligning, a number of states have obtained waiver authority to alter the Medicaid premium requirements to be more consistent with exchange plan premium and cost sharing rules. For non-Medicaid exchange plan enrollees with household income less than 133 percent FPL, the expected contribution toward premiums is 2 percent of income (26 CFR §1.36B-3(g)(2)). In Iowa, beneficiaries with income between 100 and 138 percent FPL will pay $10 per month.[19] Premiums will be waived for all enrollees in the first year of eligibility and waived in subsequent years if enrollees self-attest to financial hardship or undertake certain healthy behaviors, such as a health risk assessment and an annual wellness exam (CMS 2014b).[20] The state will monitor who completes the assessment or exam through vendor and provider reports, claims submissions, and self-reports. Enrollees have the full year, plus a 30-day grace period, to comply. In future years, the state intends to add the ability for enrollees to earn financial rewards for completion of other healthy behaviors, such as a smoking cessation program (CMS 2014d).

States also are interested in testing different approaches to cost sharing that mimic private-sector practices, such as requiring enrollees to contribute a certain amount toward an account similar to a health savings account (HSA) that can later be used to pay for per-service charges. Arkansas has received approval for an amendment to its waiver for the use of Independence Accounts for those enrolled in exchange plans. Enrollees will be charged monthly contributions ranging from $5 for those with income above 50 percent FPL to $25 for those at 133 percent FPL (CMS 2014a). Technically, the amounts paid into the savings account will go toward copayments that are in line with existing Medicaid requirements; however, requiring monthly payments regardless of service use is similar to charging premiums,

although enrollees cannot be denied eligibility for nonpayment.

Both states are limiting enrollee exposure to out-of-pocket spending. In Iowa, the state will be charging premiums in lieu of other cost sharing (except for a copayment for non-emergency use of the emergency department). Additionally, individuals who participate in healthy behaviors will be exempt from premium payments. Arkansas secured an amendment to its waiver to implement an HSA-like account. The approved amendment stipulates that no household shall pay more than 2 percent of income toward the monthly contributions and cost-sharing provisions are consistent with Medicaid requirements (CMS 2014a). In both states, the 5 percent of income aggregate cap remains in force.

There is a potential risk to these approaches, as increased cost sharing can discourage people from seeking coverage and needed care, and financial incentives for healthy behaviors have shown limited success. Specifically, studies have found that charging low-income families premiums depresses enrollment by serving as a barrier to both obtaining and retaining coverage (Snyder and Rudowitz 2013, Abdus et al. 2014, and Wisconsin 2014); and although per-service cost sharing has been shown to reduce the use of less-essential services, it can also serve as a deterrent to seeking needed care and may result in the use of more expensive services (Snyder and Rudowitz 2013 and Swartz 2010). Additionally, the use of financial incentives for healthy behaviors has had mixed results in other states (Blumenthal et al. 2013). Close monitoring of the impact of premiums and other cost sharing on enrollment, access, and utilization, as well as the use of incentives to reduce enrollees' financial liability, will help inform further demonstrations.

Protections Available to Medicaid Enrollees

A number of consumer protections are preserved in the existing premium assistance waivers, and while important, these provisions may complicate program administration and raise costs. Specifically, although there is no consensus on the most accurate approach, states must establish policies and procedures to identify medically frail individuals, who are exempt from enrollment. Additionally, retroactive eligibility for Medicaid is maintained, and, in both Arkansas and Iowa, enrollees will access benefits through Medicaid until enrollment in the exchange plan is effectuated. Finally, despite enrollment in private exchange plans, enrollees retain their grievance and appeals rights, although states may delegate certain appeal responsibilities.

Exemptions for people identified as medically frail. States adopting premium assistance must identify medically frail individuals among those now eligible for Medicaid and give them the option of enrolling in the traditional Medicaid plan (42 CFR 440.315).[21] States have discretion in determining how these individuals will be identified, which might include self-identification, provider identification, or a review of claims information by either the issuer or the state. In Iowa, there are three ways that an enrollee may become medically exempt—through a member survey, provider attestation or referral, or through a retrospective claims analysis (Iowa 2014d). In Arkansas, applicants are identified through a screening questionnaire or must seek a determination of medical frailty (CMS 2014a). There are concerns about self-identification as an approach to identifying the medically frail because self-reports of health status may be unreliable when individuals are seeking benefits, especially given the historic exclusion of coverage for preexisting conditions in insurance. There also are concerns about relying on claims analyses. If this analysis is left to the plans, there is a financial incentive to move those with certain conditions to

traditional Medicaid, regardless of whether or not they fit the criteria of medically frail.

Retroactive coverage. Medicaid coverage is effective as of the date of application or the first day of the month in which an application is filed, whereas exchange plan eligibility is prospective, meaning that, coverage will begin, at the earliest, on the first day of the next month (42 CFR 435.915 and 45 CFR 155.420(b)(1)). As such, there is a potential for misalignment in coverage effectuation dates. In addition, Medicaid coverage must extend three months retroactively if the individual would have been eligible during that time—a requirement that remains in place for the premium assistance programs in Arkansas and Iowa (42 CFR 435.915). This provision may protect beneficiaries from certain out-of pocket costs by allowing medical care received prior to application to be covered by Medicaid, a benefit to the provider who saw these patients as well. As such, in a premium assistance approach to coverage, states may need to cover beneficiaries in their fee-for-service programs until exchange plan enrollment takes effect and also retrospectively. There is precedent for this as states using managed care or presumptive eligibility will typically cover individuals in fee for service while managed care enrollment or a full determination is effectuated. In both Arkansas and Iowa, enrollees are able to access benefits through Medicaid retrospectively and until enrollment in the exchange plan is finalized (CMS 2014a and CMS 2014b).

Appeal rights. Medicaid applicants and beneficiaries have a right to adequate notice and the opportunity to challenge an adverse state action before an impartial party. Enrollees also continue to receive treatment while an appeal is pending (42 CFR 431.200-250). In addition, Medicaid enrollees in managed care must have access to plan-level procedures to appeal decisions made by the MCO, for example, denial of a requested service (42 CFR 438.400-424). Standard appeals should be resolved within 45 days, but MCOs must have in place a process for expedited review (42 CFR 438.408-410). Exchange plans, like all individual and group plans, are required to have an internal claims process as well as to give access to an external review process (45 CFR 147.136). While eligibility appeals across programs are required to be coordinated, there is no such requirement for denial of benefits or claims appeals (45 CFR 155.510). States may delegate certain appeal responsibilities to the department of insurance or another state agency. As such, while enrollees' Medicaid appeals rights are maintained, it is unclear who appeals should be directed to, if and how they will be coordinated, and who bears ultimate responsibility for adjudication. Therefore, enrollees' ability to navigate the appeals process will need to be monitored.

Cost Implications of Premium Assistance

A key question about premium assistance models are their cost compared to that of traditional Medicaid. Federal policy requires Section 1115 demonstration waivers to be budget neutral, meaning that federal Medicaid spending under the demonstration is equal to or less than it would be in that state without the demonstration.[22] Whether or not that proves to be the case will be a function of several factors, including the costs of coverage, the population that enrolls, and whether the larger impact on federal spending is considered.

Using premium assistance to purchase private market plans—which, historically, have been more expensive than Medicaid, due in part to higher provider payment rates—would likely be more costly (Ku and Broaddus 2008). On the other hand, by continuing to serve medically frail individuals (those with the highest needs) in traditional Medicaid, it is more likely that the cost per person will be higher in comparison to those enrolled through premium assistance.

Additionally, providing Medicaid enrollees coverage through an exchange plan might be a cost-effective

approach if other factors, such as the composition of the exchange, are taken into consideration.[23] In the case of Arkansas, an additional 200,000 people who would have been covered in the Medicaid program are enrolled in exchange plans (Ramsey 2014). As a result, enrollment in the exchange substantially increased, which has the potential to lead to a healthier risk pool (ASPE 2014).[24] Additionally, if larger numbers of enrollees are expected in the exchange, more issuers may be interested in capturing a piece of the market, thereby increasing competition as they join. Finally, as a large purchaser in the exchange, Medicaid may be in a position to negotiate lower rates. These factors may lead toward lower premiums overall.[25]

The impact on the broader exchange market suggested in Arkansas may not be the case for other states, in part due to the size and health status of the expansion group as compared to those enrolling in the exchange. In Iowa, only individuals between 100 and 138 percent FPL are enrolled in exchange plans, and an insurer participating in the premium assistance plan has reported that the population is higher cost than the company's other exchange business (Pradhan 2014). However, it is not known what impact this has had on the broader exchange market given the smaller share of enrollees the program represents.

The federal government currently is paying the full cost of coverage for newly eligible individuals in the adult expansion group, although this matching rate will begin to decrease in 2017, requiring a state contribution of 10 percent in 2020 and onwards. Therefore, the cost of exchange plan coverage, with the added expense of benefit and cost-sharing wraps—especially compared to traditional Medicaid on a per-person basis—is an important consideration for both states and the federal government as the merits of premium assistance are weighed.

Need for Thorough Evaluation

To date, premium assistance has never been attempted on such a scale, and this approach to coverage could be informed by a robust evaluation as required under the statute and regulations. Specifically, because Section 1115 waivers are experiments, pilots, or demonstration programs, they require evaluation (42 CFR 431.424). Important factors to consider in an evaluation of premium assistance include:

1. the extent to which the approach results in covering more individuals than would have been the case without the expansion;
2. the effect on access to care;
3. whether enrollees are able to access necessary benefits through a wrap, and the process for administering the wrap;
4. the effect on access to care from restricting the use of non-emergency medical transportation;
5. the impact of premiums, cost sharing, and incentives for healthy behaviors on enrollment and service utilization;
6. whether exchange plan enrollment eases transitions and improves continuity of coverage and care as enrollee income changes;
7. the accuracy of the medically frail exemption screening and the health of those enrolled in premium assistance compared to traditional Medicaid;
8. the larger effect on the exchange market in terms of competition and costs as a result of purchasing exchange plans for the Medicaid population; and
9. the overall costs to the state and federal Medicaid program and federal spending generally.

The terms and conditions of the waivers include evaluation requirements, although the specific research questions and design are settled through a subsequent approval process. States must submit an evaluation design plan that includes a discussion of the hypotheses, the data and methods of collection, how the impact of the waiver will be isolated, and a timeline (42 CFR 431.424). Updates on enrollment will occur earlier on in the evaluation process, with implementation updates and outcomes data coming later. Final reports will not be due to CMS until the end of 2017 and must be available publicly.

While not the only purpose, the evaluations will look at whether or not the waivers were cost effective in a manner that takes into account both the initial and the longer-term costs and implications, such as health outcomes. There also are specific research questions that the evaluations will be designed to answer, for example, whether premium assistance beneficiaries have equal or better access to care, fewer gaps in coverage, continuity of provider access, and satisfaction with services. Additionally, the evaluations will examine whether enrollees, such as young adults entitled to EPSDT, are able to access benefits through the wrap. In Iowa, the state will also investigate whether the lack of NEMT poses a barrier to access as well as the impact of premiums and the incentives for healthy behaviors (CMS 2014a, CMS 2014b, ACHI 2014, and IPPC 2014).[26]

Neither the Arkansas nor the Iowa evaluation plan requires an examination of the effectiveness of their approaches to identifying the medically frail. However, Iowa is planning on examining the medically frail population to assess its access to care and detail the services provided that would not have been provided under the waiver, and Arkansas indicates that additional refinements may be made to its screening approach after data on the results and actual utilization become available (IPPC 2014 and ACHI 2014). Arkansas also has identified a number of supplemental hypotheses for future examination, including looking at the impact on the exchange market (ACHI 2014).

Additionally, Mathematica Policy Research has been awarded a contract by CMS to conduct a national examination of Section 1115 waivers.[27] Initially, the evaluation will examine implementation, primarily through the use of interviews and state documents, to assess the variation in state designs. The outcome focus of the evaluation will not begin until 2016, with public results likely in 2019. This portion of the evaluation will assess the differences in outcomes between premium assistance and traditional Medicaid in terms of take-up, access, quality, and spending (Irvin 2014).

As with all evaluations, there will be limitations on the strength and generalizability of their conclusions. Both states have unique characteristics that make it difficult to extend conclusions to the country as a whole. For example, Arkansas was a fee-for-service state prior to the expansion, which may lead to differing results when comparing costs to what would have occurred in a managed care state. Iowa chose to enroll only those who would have been eligible to enroll in an exchange plan if there was no Medicaid expansion (those with income between 100 and 138 percent FPL), limiting the population subject to the demonstration, although perhaps to one that is more similar to a commercial population. There also is the added difficulty of identifying and collecting data on an appropriate comparison group, which is especially acute in Arkansas given the state's low Medicaid eligibility thresholds prior to the expansion. Finally, isolating the effect of the premium assistance approach, or any other waiver feature, will be complex given the other payment initiatives (such as the State Innovation Models [SIM] grants) occurring at the same time.

Conclusion

The purchase of exchange plans for Medicaid enrollees is a new phenomenon, with coverage available in just two states since January 1, 2014. Therefore, little data are available to judge the

relative impact. Each waiver includes an evaluation that will provide a more thorough assessment of the approach, and there is widespread interest among the research and policy community more generally to have a better understanding of the impact of premium assistance. As such, while data currently may be limited, it is expected that more will become available given this broad interest.

A complete assessment of the questions raised here regarding the adequacy, continuity, and cost of premium assistance also will help to address whether its use should be broadened in Medicaid and CHIP. Of the 22 states that have not expanded Medicaid, some may seek alternative approaches. For example, the governor of Utah has proposed an expansion that would include the purchase of exchange plans for Medicaid enrollees (Utah 2014).

The premium assistance model also is relevant beyond newly eligible adults. For example, there have been discussions of the use of premium assistance in the exchanges for children now covered by CHIP.[28] The experience of Medicaid-eligible adults enrolled in exchange plans could help inform the viability of such an approach for children. In addition, beginning in 2017, states may seek innovation waivers to develop alternative approaches to meeting the ACA coverage goals. The plan must be at least as comprehensive and affordable as coverage under the ACA and cover as many residents, and it must not increase the federal deficit. Premium assistance also could play a role in these so-called super waivers.

Looking forward, MACPAC will continue to monitor the implementation of the premium assistance option in Arkansas and Iowa, as well as any additional states that choose such an approach, reporting on any available data regarding the impact of the waivers and the potential implications for Medicaid and the broader exchange market.

Endnotes

[1] The new adult group consists of non-elderly adults previously ineligible for Medicaid, specifically adults without dependent children with incomes at or below 138 percent FPL and parents with incomes above pre-ACA eligibility thresholds, but at or below 138 percent FPL.

[2] Arkansas is enrolling all adults in the new adult group in exchange plans, except for the roughly 10 percent of individuals who qualify as medically frail. Iowa is purchasing exchange plans for Medicaid-eligible individuals with incomes between 100 and 138 percent FPL who do not have access to cost-effective employer-sponsored insurance (those who would have been eligible to enroll in exchange coverage if the state had chosen not to expand Medicaid), with traditional Medicaid covering those in the new adult group below 100 percent FPL.

[3] In traditional premium assistance models, enrollment could be mandatory or voluntary depending upon the authority under which the program operated and state policy. For example, under Section 1906A Health Insurance Premium Payment Programs, individuals could be required to enroll in employer-sponsored coverage if the option was deemed cost effective by the state. Under the 1115 waiver in Arkansas, enrollment in an exchange plan is mandatory except for enrollees who are medically frail. In Iowa, after one of the two exchange plans withdrew from the market, the state will no longer require enrollees with income above 100 percent FPL to enroll in an exchange plan as a condition of eligibility. Instead, enrollees will have a choice between the remaining exchange plan or the state's Wellness plan, designed for those in the new adult group with income up to 100 percent FPL.

[4] Other instances of overlap between Medicaid and the private market exist. For example, Medicaid serves as the payer of last resort for individuals who have another source of coverage, as statute requires health insurers and other third parties, such as workers' compensation, to pay claims prior to the Medicaid program covering the cost of any care received by the enrollee. Medicaid also provides supplemental coverage for individuals, such as children, who have special health care needs but whose private plans do not provide the depth of benefits they need. Additionally, Medicaid covers Medicare Part A and Part B premiums and cost-sharing expenses for certain groups of low-income Medicare beneficiaries through the Medicare Savings Programs (MSPs).

[5] This includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs.

[6] New Hampshire submitted a Section 1115 waiver request on November 20, 2014, to use a premium assistance model for its expansion beginning in 2016.

[7] If the alternative benefit package is delivered through an MCO, states must comply with the managed care rules (42 CFR 440.385).

[8] Both Arkansas and Iowa are operating in partnership with the federal exchange and maintaining plan management functions for the exchange plans sold. This oversight authority would likely enable the department of insurance to require exchange plan issuers to share additional plan data with the Medicaid agency (CMS 2014c and CMS 2013a).

[9] CoOportunity Health withdrew its participation in the Iowa waiver as of the end of November 2014. The enrollees covered by the issuer were transitioned to the Iowa Wellness Plan (the portion of the waiver covering those with income below 100 percent FPL not enrolled in exchange plans) as of December 1. New enrollees will have the choice of receiving coverage through the remaining plan, Coventry, or enrolling in the Wellness Plan. As of December 2014, CoOportunity Health is no longer offering plans for non-Medicaid individuals in the Iowa exchange either (Iowa 2014b).

[10] In Minnesota, for example, HMOs cannot obtain a license to sell private plans unless they are fully participating in Medicaid (Buettgens et al. 2012). Considerable overlap already exists between the exchange markets and Medicaid. For the 2014 open enrollment period, 41 percent of exchange plan issuers also operated Medicaid managed care plans in the states, although in 18 states there was no overlap in issuers (ACAP 2013).

[11] Another option is for states to establish transition plans for individuals moving between coverage sources. For example, Maryland recently enacted legislation that allows those with acute conditions or serious chronic conditions, pregnancy, or mental health or substance use disorders to

continue to receive services from an out-of-network provider for a limited time (Maryland Health Progress Act of 2013, H.B. 228). In 2015, Delaware will require its exchange plans to have transition plans for those who become eligible or lose eligibility for a public health program, which must include a transition period for prescription drugs (Delaware 2014).

[12] Medicaid must provide access to care comparable to that of the general population. Medicaid managed care plans must maintain a sufficient number, mix, and geographic distribution of providers and cover out-of-network services if the network is unable to provide them (42 CFR 438.206-207 and 42 CFR 438.52). Federal rules require exchange plans to offer networks that are sufficient in number and types of providers, including those that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay, but do not require an out-of-network option except in cases of emergency (45 CFR 156.230). They also must provide access to essential community providers (45 CFR 156.235).

[13] With prior plan approval in both Medicaid managed care and exchange plans, it is possible to obtain care outside of the network if there is no in-network provider who can provide the specific benefit or services needed; however, seeking care out of network when there are in-network providers available is not an option in Medicaid managed care, although may be an option in some exchange plans (typically with higher cost sharing).

[14] Arkansas is among the states that require insurance carriers to include all providers in their networks if they meet certain conditions (including accepting the plan's rates as payment), and as a result, plans in Arkansas may be less likely to have narrow networks (Noble 2014). Access to providers may unfold differently in states that do not have such a requirement.

[15] There is also a question of how to compare the adequacy of networks. Typical measures of network adequacy include time and distance standards to providers, wait times for appointments, provider to patient ratios, and the inclusion of certain safety net providers. However, there are no consistent standards for these measures used across states, such as one primary care provider for every 100 enrollees. A recent HHS Inspector General (OIG) report found that state provider access standards for Medicaid managed care vary widely and are not specific to the type of provider or area of the state (OIG 2014).

[16] Access to out-of-network family planning services also is preserved. Specifically, if family planning services are sought from an out-of-network provider, the state's fee-for-service Medicaid program will cover those services. Premium assistance enrollees also must have access to at least one exchange plan that contracts with at least one federally qualified health center (FQHC) or rural health center (RHC).

[17] Iowa requested a waiver of EPSDT for 19- and 20-year-olds in its expansion population, but it was not granted (Iowa 2013).

[18] Under Section 1115 authority, the Secretary can waive premium requirements; however, Section 1916(f) sets limits on changes that can be made to cost-sharing provisions through a waiver.

[19] The premiums in Iowa constitute about 1 percent of an individual's income between 100 and 133 percent FPL. Iowa's original approval letter restricted the state from imposing premiums that exceeded those in the exchange and the special terms and conditions specified that premiums could not exceed 2 percent of income (CMS 2013c). The waiver terms were revised, allowing for the imposition of $10 monthly premiums (CMS 2014b).

[20] The hardship exemption in Iowa is only effective for the month requested and not for the entire year; however, enrollees are able to self-attest to a financial hardship each month.

[21] Certain groups are exempt from enrollment in the ABP, an exemption that applies if a state adopts an ABP that does not align with the state's Medicaid program, including when the state is using an exchange plan premium assistance approach to coverage. Given that many exempt individuals may be eligible for coverage under another eligibility pathway (e.g., disability-related coverage), the exempt population most likely to be enrolled in the new adult group is the medically frail. The federal definition of medically frail includes individuals with disabling mental health disorders, chronic substance use, serious and complex medical conditions, a physical or mental disability that significantly impairs their ability to perform one or more

activities of daily living, or other special medical needs (42 CFR 440.315(f)).

[22] While the actual cost to enroll the demonstration population in exchange plans is known, it is not possible to compare the cost to the same population enrolled in direct Medicaid coverage because that group did not exist prior to 2014 (and will not exist in states that enroll the entire expansion population in exchange plans). Therefore, CMS has allowed states to estimate costs for the expansion population, then adjust that limit if actual costs under the demonstration are higher than initially projected. In September 2014, the U.S. Government Accountability Office (GAO) raised concerns that this approach increases the risk that these demonstrations will not be budget neutral (GAO 2014).

[23] Under the regulations governing premium assistance in the individual market, the purchase of such coverage must also be cost effective (42 CFR 435.1015(a)(4)). This means that the total cost of purchasing such coverage, including administrative expenditures, the costs of paying all excess cost-sharing charges, and the costs of providing wrap-around benefits, must be comparable to the cost of providing direct coverage under the state plan. Both Arkansas and Iowa received waivers of this provision, although were required to establish an alternative method for determining cost effectiveness (CMS 2014a and CMS 2014b).

[24] Outside the Medicaid expansion population, the number of individuals who had selected an exchange plan in Arkansas between October 1, 2013 and March 31, 2014 was 43,446.

[25] While there is little evidence to this point, the Arkansas waiver suggests that the demonstration also will lead to more competitive premium pricing by doubling the size of the population enrolled (CMS 2014a). The idea of additional carriers joining the exchange market has been discussed by former Arkansas Medicaid Director Andy Allison (Allison 2014).

[26] Arkansas also is required to evaluate whether enrollees have appropriate access to NEMT. However, the amendment in Arkansas requiring the use of Independence Accounts did not require evaluation of the new cost-sharing approach, although it may be added into the evaluation plan at a later date.

[27] The evaluation is examining four types of Section 1115 waivers, including premium assistance and healthy behaviors/value-based purchasing initiatives as well as delivery system reform incentive payments (DSRIP) and managed long-term services and supports (MLTSS).

[28] For example, at its December 2014 meeting, the Commission discussed the use of a premium assistance approach to supplement the benefits and cost sharing for children who move from CHIP coverage to exchange plans following the expiration of CHIP funding.

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